A DESCRIPTIVE STUDY OF TYPES OF SOCIAL SERVICE REFERRALS OCCURRING DURING THE FIRST SEVENTEEN MONTHS OF OPERATION OF THE NEW YORK STATE UNIVERSITY DOWNSTATE MEDICAL CENTER

A THESIS

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TABLE OF CONTENTS

LIST OF TABLES

Title (See Appendix II)

STATEMENT OF THE PROBLEM

In the modern day hospital emphasis is placed upon, "Total Health Care".[1] Since the physician, according to our laws and customs is the only individual who may practice medicine, and considering the fact that he possesses but a few of the skills involved in the treatment or management of the problems associated with illness or injury, the term, "Medical Care", is inappropriate. "Health Care", would seem to be a much more fitting term. Health Care is defined by the American Hospital Association as the application of all skills needed to solve or alleviate the problems associated with disease or injury, including the residuals of either.[2] This definition entails utilizing the services of many different disciplines, doctors, nurses, physical therapists, psychiatrist, social workers and etc.

The physician even in private practice is, in fact, only part of a community's coordinated efforts to provide health and welfare services for its citizens. While the physician may carry on the essentials of the healing arts

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[1] Albert Tomasula, "The Impact of Changing Concepts of Medical Care," Social Work, III (April, 1963), 65.

[2] American Hospital Association, Essentials of a Social Service Department in Hospitals and Related Institutions. (Chicago: American Hospital Associations, 1961), p. 1.

within the confines of his office, in most instances, he is also involved with a multiplicity of other individuals and agencies such as the hospitals, health insurance companies, rehabilitation units and frequently, social agencies. Since this is so, medical education needs to incorporate a general knowledge of helping agencies and must teach methods of utilizing these community resources toward a coordinated effort in providing services.[3]

Too often, collaborating professions in the hospital setting lack appropriate knowledge of each other's function. This results in inefficient use of available services. This investigator feels that the quality of treatment provided for a given patient has a good deal to do with the degree of appropriate use of helping disciplines. An inadequate understanding of the functioning of each discipline by the other is a hindering factor that cannot be over-emphasized.

The shortage of trained graduate workers to man social work programs has been an acute problem for a long time and remains a matter of constant concern. Serious as it is, the situation is compounded by increasing demands for trained workers and their continuing departure from the field.

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[3] Eric S. Edelson, "The Changing Role of the Social Worker in Medical Education, "Social Work, X (January, 1965), 81.

Margaret Heyman indicated that in 1961 there was an almost fixed number of available workers.[4] Many references have been made in the professional literature to the necessity of using trained workers to the best advantage. References have also been made, particularly in the hospital field, to the urgent need for changes in staffing patterns in hospital social service departments so as to assure more efficient use of professional social workers.

Many referrals to social service could possibly be handled by personnel without full professional training. This study will endeavor to point up the extent to which non-professionals may be utilized.

It will attempt to show how much movement or lack of movement in understanding social service department function was realized by collaborating professions during the periods under study, and what needs to be done to further the understanding of practitioners of related collaborating professions with the functions of the social service department.

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[4] Margaret M. Heyman, "A Study of Effective Utilization of Social Workers in a Hospital Setting," Social Work, VI (April, 1961, 36.

SIGNIFICANCE OF THE STUDY

A social service department functioning as an integral part of a health care program provides a major advantage for a hospital of any size in its service to patients. Whatever the adaptation, the goal remains the same; to contribute to the total medical care provided by the health team and is directed toward the achievement of the optimum state of health of the patients.

The present state of health services may be said to include numerous skills for the care of the patient, his disorder, his environment and all related problems.[5]

The contributions of social service are:

1. Aiding the health team in understanding the significance of social, economic and emotional factors in relation to the patient's illness, treatment and recovery.

2. Helping the patient and his family in their understanding of these factors, to enable them to make constructive use of medical care.

3. Promoting the well-being and morale of the patient and his family.

4. Participating in the educational programs of other members of the health team.

5. Assisting the hospital in giving better patient care through its various services.

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[5]Albert Tomasula, "The Impact of Changing Concepts of Medical Care," Social Work, III (April, 1963), 68.

6. Facilitation: the productive utilization of community resources to meet the needs of patients and their families.[6]

The fullest measure of service to the patient can be enhanced through the close collaboration of the various professional disciplines represented on a health team. Consequently, it is important that a new social service department direct its attention to the development and maintenance of an administrative structure for collaborating with all members of a health team on behalf of patients. Realistically speaking, however, this cannot always be accomplished to the extent to which it is ideally desirable. Initially, it is well to broaden the base of referrals. This enhances communications with the hospital staff. However, referrals which are clearly not within the framework of social service should not be accepted.

In the final analysis collaboration becomes a gradual process, limited, nevertheless, to activities which rightfully belong within the framework of social service. In this way, it is possible to demonstrate in the organizational phase, the need for sound collaborating practice and thereby evolve a structure which can implement the expressed need of meeting

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[6]American Hospital Association, "Essentials of a Social Service Department in Hospitals and Related Institutions," p. 1.

together with other disciplines to provide a full measure of service to patients.[7]

In recognition of the need for collaboration, and in order to enhance better understanding of functions of the various disciplines, hospitals have expanded their overall teaching programs to encompass the social service department. This entails members of social service conducting social service teaching programs for nurses, interns, residents as well as hospital administrators.[8]

Once optimal understanding of social service function has been achieved by collaborating professions, other areas of concern arise. Many referrals are made which do not require the skills of a fully trained worker.

With the traditional method of assigning professional staff in a hospital, that of giving each worker total social service responsibility in a particular clinic or service a professionally trained caseworker performs a variety of services which may or may not require his full skills. Such utilization of staff is not economical. Under-utilization of

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[7]Sidney Hirsh and Abraham Lurie, "Establishing a Hospital Social Service Department", Social Work, II (April, 1959), 90.

[8]American Hospital Association, "Essentials of a Social Service Department in Hospitals and Related Institutions," p. 6.

the trained worker's full skills not only lessens effectiveness, but the best interest of the patient as a whole may not be served.

The ideal situation would be utilization of professionally trained caseworkers at the level of their greatest skill, so that either more or better service and hopefully both will be available to patients and their families.[9] It therefore follows that the case aide could be of great value to the hospital by handling activities falling within the social service framework, but not requiring the skills of a professional trained practitioner. The investigator was the second social worker to be employed in the social service department at the State University Hospital, Downstate Medical Center. Therefore, the problems with which the study is concerned were faced on a day by day basis.

Two of the most obvious factors for consideration were: (1) Lack of full understanding on the part of collaborating professions of social service function. This necessitated an initial broad based approach to referrals. As a result, much time was wasted, separating actual social service cases from non-cases. (2) As time progressed and more actual social

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[9]Heyman, "Social Workers in a Hospital Setting," p.36.

service cases were referred, in many cases, social work staff found that time needed for actual casework practice was used in other activities which did not necessarily require skills of a fully trained social worker.

These two factors caused the investigator to wonder if any progress has been made by the collaborating professions in their effort to more efficiently utilize social service. The progress will be measured by observing the trend in referrals for tangible and intangible referrals. The investigator further wondered about the extent to which case aide personnel could be of service at the State University Hospital, Downstate Medical Center.

It was with the above stimuli that the investigator was motivated to embark upon this study. Through this endeavor the investigator will attempt to become more knowledgeable as to what constituted the types of referrals initially as well as what constituted the types of referrals at the termination of this study.

Using the hypothesis, "disciplines lacking an adequate understanding of social service function in a hospital setting tend to refer patients predominantly for tangible services", the investigator hopes to indicate a movement in understanding of social service function by measuring the proportion of tangible to intangible service referrals during the first half of the period under study as opposed to the second half.

Some authorities contend that many intangible services can be provided by a person without full professional training, this study will enable the agency director to see more objectively the extent to which non-professional personnel can be used in a medical social work setting.

By providing him with a knowledge of the nature of the predominant kinds of referrals, the director will know what specific services are being requested most frequently. He will, therefore, be able to plan more efficiently for in-service training programs.

CHAPTER II

DESCRIPTION OF REFERRAL PATTERNS OF THE ORGANIZATIONAL STAGE AND THE TERMINATION STAGE

Introduction

Teaching and Interpretation, an Aspect of the Social Worker's Role, as It Relates to Referrals

It is the feeling of the investigator that teaching and interpretation is of very great importance in a medical setting. It is the investigator's contention that the Social Service Department in a given medical setting is used more frequently, and more efficiently, as the understanding of its function, by those responsible for referring cases, increases. The need for extensive teaching and interpretation takes on added meaning when one realizes the social worker's vague and unclear position, as perceived by many collaborators.

Social work in the hospital is only one of the many diverse ancillary services in a large and complex social organization whose primary function is the providing of medical care. As a secondary professional service within the hospital, it must always be related to the primary requirements of medical treatment. In many hospitals, social work is still not fully accepted. In some instances, rather than enjoying acceptance, as an important and essential service, it is more or less tolerated. This situation occurs partially because of social worker's area of professional competancy is difficult to recognize, since he does not

deal directly with the patient's apparent physical illness. To a greater extent, on the other hand, it is the result of many physician's tendancy to view patients as medical cases rather than as whole persons.[10] The human system is not merely biological, but psychobiological; as a consequence the practice of medicine should be based on a knowledge of the personality as well as the body.[11]

Within the hospital setting, several types of activties such as arranging post hospital care and making referrals for community services (tangible services) are widely accepted. The activities that produce the most difficult conflict presently appear to be those that involve a psychotherapeutic approach to social and emotional problems.[12]

The teaching role of the social worker was initially assumed as an undeclared purpose in order to bring about some awareness on the part of doctors, nurses, and other collaborators, of the social and emotional factors in illness and recovery. This was initially an informal role and consisted mainly of working case by case to improve social attitudes and to provide doctors with knowledge which would give them more understanding of the psychodynamics of behavior.

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[10] Catharine M. Olsen and Marion E. Olsen, "Role Expectations and Perceptions for Social Workers In a Medical Setting," Social Work, XII (July, 1967), 70.

[11] Ruth Smalley, "Psychiatric Implications for Medical Social Work," The Family, XV (December, 1934), 257.

[12] Olsen, op. cit., p. 78.

Today, in addition to the informal teaching role, social workers, particularly in teaching hospitals, such as State University of New York, Downstate Medical Center, have moved into a more formal type of teaching assignment. They serve as lecturers, consultants, as well as in joint preceptoral responsibilities. More and more, the teaching function of the medical social worker is emerging as a recognized part of medical school and hospital administration.[13]

In his quest to promote more efficient use of his services, in addition to his teaching function, the social worker must assume the role of interprofessional interpreter. Those who function in an interprofessional setting in many cases, are aware of the importance of the process of association and communication in obtaining and testing knowledge for the good of the whole. The social worker is in a key position as an interprofessional interpreter. To interpret, one must understand. For many years schools of social work have included in their curriculum: medical, psychiatric and psychological information.[14]

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[13] Eileen Blackey, "Social Work in a Hospital: A Sociological Approach," Social Work, Vol. No. I, (April, 1956), 46.

[14] Alice E. Abbe, "School Agency Cooperation: An Account of Working Together In An Urban Community," Social Work, II (October, 1957), 72.

The data to follow is representative of referral patterns of the two periods under study. The latter period represents hopefully a higher degree of sophistication on the Social Service Department. This is primarily because of the Social Service Department's ongoing teaching and interpretation programs. In view of this, it will be interesting to ascertain the differences existing in the referral patterns of the respective periods.

It is hoped that the information presented will provide the reader with a frame of reference which will enable him to better understand and appreciate a description of referral patterns of the Organizational and Termination Stages.

The Nature of Tangible Referrals During the Organizational Stage (I) and The Termination Stage (II)

As illustrated in tables 1 and 2, the investigator discovered that the number of different kinds of tangible referrals and the number of referral sources for both periods under study totaled fifteen (15) and twenty-five (25) respectively.

The list of referral kinds is comprised of the following:

1. Financial Assistance (welfare aide)
2. Home Appliances (telephones)
3. Employment Finding (helping patient to secure employment)
4. Employment Correspondence (letters or forms concerning social security liability)
5. Vocational Rehabilitation (outside referral to Division of Vocational Rehabilitation for job training compatible with a given patient's condition)
6. School Placement (aiding a patient in reentering school or obtaining a home instructor)
7. Homemaking Services (helping the patient in obtaining an individual to perform household chores)
8. Visiting Nurse Services (helping patient in obtaining periodic nursing care in the home)
9. Child Care (helping patient to obtain someone to care for children during hospitalization or clinic visits)
10. Adoption Services (outside referral to Bureau of Child Welfare for adoption planning)

11. Convalescence Care (helping in obtaining convalescent homes or nursing homes)

12. Medicare-Medicaid (problems having to do with the application of these two programs for medical aid. The former is federal oriented, the latter is state oriented)

13. Housing Problems (problems having to do with home finding, heating, maintenance, etc.)

14. Transportation (problems having to do with travel to and from hospital or clinic)

15. Locate Patient (efforts to ascertain whereabouts of patients who were consistent in failing medical appointments)

The list showing the referral sources for the two periods is comprised of the following medical services:

1. General Medicine
2. Diabetics
3. Arthritics
4. Surgery
5. Pediatrics
6. Clinical Research
7. Pre-natal
8. Hematology
9. Renal
10. Cardiology
11. Rehabilitation Medicine
12. Family Planning
13. Outside Source
14. Neurology
15. Trauma
16. Dernatology
17. Pulmonery
18. Gynecology
19. Radiology
20. Res. Follow-up
21. Urology
22. Opthalmology
23. Psychiatry
24. Orthopedics
25. Obstetrics

The nature of tangible referrals during the Organizational Stage (I) and the Termination Stage (2) can be readily seen by referring to Tables 2 and 4 respectively. The investigator discovered the following.

Financial assistance referrals greatly outnumbered all others. Out of a total number of 105 tangible referrals during the Organizational Stage (I), financial assistance referrals comprised 51 percent. Out of a total of 107 tangible referrals during the Termination Stage (2), financial assistance comprised 37 percent.

Employment finding held second place among the tangible referrals. The Organizational Stage (I) yielded 9 percent, the Termination Stage (2) also yielded 9 percent.

The remainder of referrals comprising the bulk during the Organizational Stage (I) are as follows: housing problems, 8 percent; homemaking services, 8 percent; home appliances, 6 percent; Medicaid and Medicare, 5 percent; transportation, 4 percent.

All referrals fewer in number than five are listed in a Miscellaneous category. This is true for both the Organizational Stage (I) and the Termination Stage (2). They are listed in the order of their preponderance. The referrals comprising the miscellaneous group during the Organizational Stage (I) are the following:

1. Visiting Nurse Services
2. Locate Patient
3. Employment Correspondence

4. School Placement

5. Adoption Services

6. Convalescence Care

The above list constituted a total of 10 percent. For numerical relationship, see Table 2.

For the Termination Stage (2), the remaining bulk of referrals was comprised of the following: Homemaking services 9 percent; Transportation, 9 percent; Housing problems, 8 percent; Medicare and Medicaid, 7 percent; Child care, 5 percent.

The miscellaneous group comprising 16 percent, is as follows: (for numerical relationship, see Table 4)

1. Convalescent Care
2. Home Appliances
3. School Placement
4. Adoption Services
5. Locate Patient
6. Visiting Nurse Services
7. Vocation Rehabilitation
8. Employment Correspondence

In comparing the pattern of tangible referrals during the Organizational Stage (I) and the Termination Stage (2), the following findings were obtained:

1. Financial assistance - There was a decrease of 15 percent. This catagory comprised the greatest number of referrals for both of the respective stages.

2. Employment Finding - This catagory comprised the second greatest number. It totaled 9 percent for both the Organizational and Termination Stages.

3. Homemaking Services - There was an increase of 2 percent in this catagory during the Termination Stage (2).

4. Transportation - There was an increase of 5 percent during the Termination Stage in this catagory.

5. Housing Problems - This catagory constituted 8 percent during the Organizational Stage (I) as well as the Termination Stage (2).

6. Medicaid and Medicare - There was an increase of 2 percent in this catagory during the Termination Stage.

7. Child Care - This catagory comprised 5 percent during the Termination Stage (2). There were none during the Organizational period.

8. Home Appliances - This catagory included under miscellaneous for the Termination Stage (2); there was a decrease from the Organizational Stage of 3 points.

9. Miscellaneous - There was an increase of 6 percentage points in miscellaneous referrals (see Tables 2 and 4).

The Nature of Intangible Referrals During The Organizational Stage (I) And The Termination Stage (2)

Tables 5 and 7, Intangible Referrals, of the Organizational Stage (I) and the Termination Stage (2), illustrate the nature of the referral patterns during the respective periods. The reader will please observe that the referral sources are the same as pointed out above during the investigator's discussion of tangible referrals. The kinds of referrals, on the other hand, are as follow:

1. Counsel & Support. Marital problems, problem children, poor relationships existing between family members, problems stemming from hospitalization or incapacitation of family member, etc., counselling of unwed mothers, employment counselling.

2. Social Evaluations

3. Psychiatric Screening (psychiatric evaluation to determine whether a given prospective patient is suitable for the psychotherapy program)

4. Post Hospital Planning (This category was dealt with in terms of specific services)

In contrasting the Intangible referrals during the Organizational Stage (I) and the Termination Stage (2), we can see the differences in pattern readily by observing Tables 6 and 8. The reader will note that the total number of intangible referrals studied during the Organizational Stage (I) is 104. The total number for the Termination Stage (2) is 114.

The following differences and similarities in referral patterns for the Organizational Stage (I) and the Termination Stage (2) are noted:

1. Social Evaluation (Organizational Stage (I), 36 percent; Termination Stage (2), 54 percent, comprised the greatest number of Intangible referrals for the Organizational Stage (I) and the Termination Stage (2). There was an increase of 18 percent.

2. Counsel and Support - (Organizational Stage (I), 33 percent; Termination Stage (2), 39 percent). There was an increase of 6 percent during the Termination Stage (2).

3. Psychiatric Screening (Organizational Stage (I), 5 percent; Termination Stage (2), 6 percent) an increase of 1 percent.

It is interesting to note here that intangible referrals comprised 49.6 percent of the referrals studied during the Organizational Stage (I). The percentage of intangible referrals during the Termination Stage (2) was 51.6, an increase of only 2 percent over the Organizational Stage (I).

THE SOCIAL EVALUATION REFERRAL

The investigator feels that special attention should be focused upon the intangible referral, social evaluation, or more accurately, psychosocial evaluation. It may be easily understood by those who are actively engaged in a social work practice or functioning in related fields that social evaluation is the all inclusive referral. That is, it is left up to the social worker to ascertain which specific areas of an individual's total situation or personality needs treatment or whether any treatment is indicated in the first place.

In dealing with any referral, the investigator feels that it should be kept in mind that adequate psychosocial diagnosis (psychosocial evaluation) is basic to effective social work treatment. Such diagnosis is founded upon a thorough understanding of the factors that affect personality development and change. Therefore, in socially evaluating, the social worker should be aware of the interplay between dynamic psychological factors and environmental factors. He looks to both past and present for clues to understanding.[15]

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[15] Ruth C. Abrams and Bess S. Dana, "Social Work In the Process of Rehabilitation," Social Work, II (October, 1957), 12.

CHAPTER III

THE ROLE OF THE PARA-PROFESSIONAL (CASE AIDE) AS SUGGESTED BY THE PATTERN OF REFERRALS DURING THE ORGANIZATIONAL STAGE (I) AND THE TERMINATION STAGE (2)

Introduction

Rationale for The Use of The Para-Professional, His Characteristics, and Training Considerations

The shortage of trained social workers is equal in its urgency and complexity to any of the several major problems confronting the social work profession. The ultimate goal of the profession is the provision of services adequate in quantity and quality to meet the needs of the community. The related aim is to assure professionalization. The staff shortage problem, however, makes the realization of these goals unlikely in the immediate future. This constitutes, therefore, a challenge to the profession to explore, develop and utilize all available manpower resources in the interest of extending service now to as many as possible.[16]

For those who have reservations about the use of the para-professional, the investigator feels that it is well to point out the following:

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[16] Verne Weed and William H. Sunham, "Toward More Effective Use of the Non-Professional Worker: A Recent Experiment," Social Work, VI (October, 1961), 27.

1. Exclusive reliance on professional staff in light of the continuing severe shortage of graduate workers in many instances results in no significant increase in service. In addition, this approach has the effect of overemphasizing the qualitative aspect of service at the expense of the quantitative aspect. This plays into the tendency to consider the problem on the basis of quality versus quantity rather than qualtity and quality.

2. The logic of this position tends to limit professional responsibility for developing programs to meet social needs to those which can be professionally staffed.[17]

Realizing the shortage of trained social workers, many social service agencies are utilizing case aides. An example of the wide use of the non-professional is demonstrated by statistics showing that the vast majority of positions in social welfare programs are filled by non-professional workers.[18]

Since this chapter will be dealing with the role of the case aide as suggested by the pattern of referrals during the two periods under study, perhaps it would be well, at this

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[17] Weed and Sunham, "Effective Use of the Non-Professional Worker," p. 35.

[18] William C. Richan, "A Theoretical Scheme for Determining Role of Professional and Non-Professional Personnel," Social Work, VI (October, 1961), 22.

point to familiarize the reader with a major consideration in determining the use of the case aide: client vulnerability. Client vulnerability can be divided into two types: that resulting from the nature of the client and his situation and that arising from the nature of the service.

> a. Nature of client situation - People who use the services of formal organizations vary widely in their susceptibility to damage from failure of the organization to provide skilled and responsible service.
>
> b. Worker Autonomy - (lack of guides) It is impossible to cover in any manual of procedures the infinite variety of material with which the social worker deals. Only general principles that cover situations never anticipated, and skill in applying them selectively can possibly cope with many of the problems social agencies deal with. Workers must have a chance to use disciplined discretion. Frequent approval from higher ups may help insure that they are acting in the best interest of their clients, but when decisions have to be made on the spot and situations change within the course of an interview, such constant checking is too cumbersome and may hamper the worker client relationship. In such a case, the organization has to rely upon the inner knowledge and standards of the worker.[19]

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[19] Richam, "A Theoretical Scheme," p. 24.

The investigator interprets the above information to mean that handling of cases in which there is a high potential of damage should be done by a fully trained worker. He also feels it implies that situations which require on the spot decisions, and contingencies not covered by the manual should be dealt with by fully professionally trained people.

A wide area of services falling outside of those implied above are thus left open to the case aide. The set of tasks assigned to case aides generally comprise those that are simple, more standardized and involves situations in which concrete ("tangible") needs are met. The actual content of the task varies according to the agency setting.[20]

At this point, the reader may be focusing his thoughts upon the question of the educational background usually required of para-professionals. Typically, some college training or a Baccalaureate degree in the social sciences is required.[21] Of course, there are specific consideration regarding training in addition to basic requirements. Among these are the following:

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[20]Perry Levinson and Jeffrey Schiller, "Role Analysis of the Indigenous Non-Professional," Social Work, II (July, 1966), 95, 96.

[21]Levinson and Jeffrey, "Role Analysis of the Indigenous Non-Professional," p. 96.

1. Training in regard to confidentiality.

2. Training in accepting and using authority.

3. Training in regard to over optimism and defeatism.

4. Training regarding relationship of the non-professional to professionals.

5. Training regarding over involvement in individual cases.

6. Training regarding destructive competition.[22]

The background information regarding the important aspects of the case aide is felt to be sufficient at this point. The investigator will therefore discuss the case aide in relation to his role suggested by the referral patterns of the Organizational Stage (I) and the Termination Stage (2).

DATA PRESENTATION

Tables 2 and 4 are representative of the tangible referrals received during the Organizational Stage (I) and the Termination Stage (2) respectively. Since the statistical data regarding the various referrals were discussed in Chapter II, this will not be duplicated here. Instead, the investigator will treat each referral separately and indicate what activities the investigator, as a practicing social worker at State University Hospital, Downstate Medical Center, found to be necessary. The reader will therefore, hopefully be able to see more clearly what each tangible referral entailed and how they could have been acted upon just as effectively by a non-professional or case aide.

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[22] Arthur Pearl and Frank Riessman, New Careers for the Poor (New York: The Free Press, 1966), p. 158.

Referrals for financial assistance was the predominant type by a large margin, for both periods under study. The activity involved in handling this referral was usually, helping the patients to locate the appropriate Welfare Center, providing them with letters describing their circumstances, instructing the patients as to procedures for applying, and follow through to make sure patients request for financial assistance was given adequate consideration by the Welfare Department.

Employment finding, the referral comprising the next highest number for both periods, cound be met to some extent by interviewing patient in regards to his employment history, desires and capabilities and providing him with appropriate employment resources.

The other referrals were handled as follows:

1. Homemaking Services - If patient was a welfare recipient, a letter to the appropriate welfare center explaining the patient's need and requesting a homemaker. Follow through to make sure request was given adequate consideration. If patient was not on welfare, a request was submitted to an appropriate private agency.

2. Transportation Referrals - A telephone call to the appropriate ambulance and private car serivce.

3. Housing Problems - A letter to the Department of Housing in the event of a problem such as heating, inadequate maintenance, etc. In the case of home finding, referral of the patient to an appropriate housing source, or a letter to the Welfare Department requesting permission for a given patient to use a real estate agency.

4. Medicaid - Problems in this area are at this point, handled by referring patient to the existing Medicaid Department; a department separate

from the Social Service Department set-up exclusively to handle such problems.

5. Child Care - Referral letter to the Bureau of Child Welfare.

The remaining tangible referral types listed on Tables 2 and 4 under miscellaneous were all handled by appropriate correspondence to appropriate agencies. The investigator is aware that the activities described above in relation to the respective referrals is of minimal nature, and that in some cases more extensive case work may have been indicated. Nevertheless, these abbreviated services which were of great value to the patient's well-being could have been performed by a case aide, leaving the fully trained worker free for concentration upon more involved areas of treatment.

There are two types of social service needed in a medical setting: abbreviated and full. A relatively large number of persons need help at some particular step in their immediate medical treatment. This initial contact serves as a sifting process which reveals a smaller number of persons who need a still more individualized and fuller type of case work service.[23]

It is the investigator's feeling that the abbreviated service mentioned above is represented by the tangible referrals listed. It is also felt that with proper training the case aide, after performing the abbreviated service will be

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[23]Harriet M. Bartlett, "Social Case Work: The Central Function of a Medical Social Service Department," The Family, XIX (December, 1938), 247.

able to recognize those cases requiring more comprehensive treatment and refer them to the professional worker in much the same way that the professional worker is hopefully sensitive to cases requiring a fuller psychiatric approach.

The extent of need of case aide help is pointed up by the fact that referrals for tangible services numbered approximately one half the total during the Organizational State (I) and the Termination Stage (2). (See Table 9).

CHAPTER IV

THE UTILIZATION OF THE SOCIAL SERVICE DEPARTMENT BY MEDICAL SERVICES AS REFLECTED BY THEIR REFERRAL PATTERNS, THE ORGANIZATIONAL STAGE (I) and THE TERMINATION STAGE (2) COLLECTIVELY

As the reader will see in the course of this chapter, there is quite a variation in the referral trends of the various medical services. In addition to the variation of need, the investigator feels that other factors are also responsible. The way in which the Social Service Department is relied upon for help, to a great extent is dependent upon how it is viewed by the referring sources. In many instances, following the axiom, the unknown is distrusted, rejected and feared, and considering the fact that the function of social work is generally poorly understood.[24] It is not difficult to see why the social services department is not always used as efficiently as it might be.

Other factors having to do with the referral pattern of a given discipline are:

1. Inter-role conflicts where roles do not supplement each other but are over-lapped and cross-purposed.

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[24]Alan F. Klein, "Social Work in the Non-Social Work Setting," Social Work, IV (October, 1959), 93.

2. Role ambiguity where roles are unclear, undefined, inadequately communicated or inaccurately perceived.

3. Excessive role expectation where the demands or expectations exceed the real scope of the role.

4. Non-challenging role expectation where too little is expected.[25]

Referral trends of various sources may also be influenced because a given doctor may feel that his position of dominance is threatened by the actions of his subordinates.[26]

The Social Service Department's educational program is geared toward counteracting the factors described above (see Chapter II).

DATA PRESENTATION

In describing the overall referral trends of the various referral sources, there will be no attempt to point out in verbal form, the referral trends of the individual periods under study. This nevertheless is done in Tabular form. Table 10 indicates the total number of tangible referrals with a numerical and percentage breakdown as to cources for the Organizational Stage (I). Table 11 describes the Termination Stage (2) in the manner indicated above. Table 12 indicates the total number of intangible referrals during the Organizational Stage (I) with a numerical and percentage breakdown as to sources.

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[25]Klein, "Social Work in the Non-Social Work Setting," p. 97.

[26]Alvin Zander, et al. Role Relations in the Mental Health Professions (Ann Arbor: University of Michigan Press, 1957), p. 143.

Table 13 contains this information in regards to the Termination Stage (2).

The investigator, prefers at this point, to focus the reader's attention upon the overall (The Organizational Stage (I) and The Termination Stage (2) referral trends of the various sources.

Table 14 indicates 16 major sources of referrals and 9 sources which referred so few cases (6 or less) until they were lumped together under a miscellaneous heading.

The source reflecting the greatest use of the Social Service Department was general medicine. General Medicine constituted 18 percent of the 430 referrals studied during the two periods. Other major sources were as follows: Prenatal, 17 percent; Cardiology, 9 percent; Family Planning, 8 percent; Neurology, 8 percent; and Surgery, 5 percent. For the detailed numerical and percentage breakdown, see Table 14. The weaker sources of which there were 9, comprised, collectively only 5 percent. The reader can therefore readily see the degree to which each medical service utilized the Social Service Department, and therefore formulate an idea as to which medical services (referral sources) are in need of investigation to determine the reason for their low incidence of social service use. With this information, one would be in a position to apply remedial measures.

CHAPTER V

SUMMARY AND CONCLUSION

In completing this study, the investigator has endeavored to accomplish the following:

I. Provide an index of the referral pattern of the various medical services.

In realizing this objective, it was learned that the referral sources during both the Organizational Stage as well as the Termination Stage totaled twenty-five. The reasons for referrals comprised a group of fifteen.

General Medicine and Pre-Natal were responsible for the bulk of the 430 referrals studied during the Organizational and Termination Stages. These services referred 18 percent and 17 percent respectively. The other major referral sources were as follows: Cardiology 9 percent, Neurology 8 percent, Family Planning 8 percent, Surgery 5 percent, Clinical Research 5 percent, Obstetrics 4 percent, Outside Source 3 percent, Diabetics 3 percent, Pediatrics 3 percent, Renal 3 percent, Hematology 3 percent, Rehabilitation Medicine 2 percent, Pulmonery 2 percent, Arthritics 2 percent. Those sources referring too few to be considered in the major grouping are as follows: Trauma, Dermatology, Gynecology, Radiology, Resident follow up, Urology, Opthalmology, Psychiatry and Orthopedics. This group combined comprised only 5 percent of the total of the 430 referrals studied.

In view of the above findings the investigator concludes that it would be well for the social service department to endeavor to ascertain the reasons for such a small number of referrals from the latter group and undertake to do whatever is necessary to rectify the situation. The investigator feels that it would be well also to institute a similar approach to those referral sources included in the major group but which were responsible for only a few referrals.

II. Categorize referrals in terms of requests for tangible and intangible services.

The investigator discovered that there were 15 principle referral types which fell into the category of: (Tangible Referrals). These referrals, their numbers and percentages for both the Organizational Stage as well as the Termination Stage, are listed in tables 2 and 4 respectively.

Nevertheless, the investigator feels it noteworthy that financial assistance referrals by far surpassed all the rest in this group. The total number for both the Organizational and Termination Stages was 44 percent of a total of 209. With all due respect to the probable validity of this high number of referrals for financial assistance, the investigator feels that this may in part be due to a limited understanding on the part of the referral sources as to the overall function of a social service department. The investigator wishes to qualify this by stating that during his function as a senior medical social worker, many referrals for financial assistance, after examination, called for treatment other than financial.

III. Ascertain whether or not there is a distinct difference between the percent of requests for intangible services during the Organizational Stage and the Termination Stage; the expectation here is that other departments become more aware of the kinds of services provided by the social services department, there will be more requests from these departments for intangible services.

This investigator assumed that the exposure of the collaborating professions to the social service departments educational program would result in a substantially greater number of intangible referrals during the Termination Stage. This however did not prove to be the case. During the Organizational Stage the 50 percent sample of tangible referrals studied totaled 105, the intangible referrals during this stage totaled 104. This comprised a grand total of 209. The tangible and intangible referrals during this period amounted to 50.4 percent and 49.6 percent respectively. During the Termination Stage the grand total of the 50 percent sample studied amounted to 221. Tangible referrals amounted to 48.4 percent while intangible referrals amounted to 51.6 percent (see Table 9). Although there is an increase of 2 percentage points in intangible referrals during the Termination Stage, the investigator does not feel that this minute increase in intangible referrals in significant. He therefore concludes that perhaps it would be well if the social services department could research the cause of the approximately fifty fifty relationship of intangible and tangible referrals during the two periods under study. If the Social Services Department is found to be in need of a more comprehensive educational program, this should be instituted.

IV. Provide an index as to whether or not professionally trained social workers are being utilized most effectively; in other words, are they processing referrals that could probably be handled just as effectively by para-professionals.

The investigator found that tangible referrals were approximately half the total number of referrals during the Organizational and Termination Stages. A high percentage of the tangible referrals (44 percent) were for financial assistance. The activities required to handle tangible referrals are expanded upon in Chapter III. These activities, based on the actual experiences of the investigator, are felt to be within the province of the para-professional or case aide. As pointed out previously, the investigator is aware that in many cases activity beyond that which is called for in the initial referral is required. However, it is felt that with ample supervision and training the case aide may work effectively within his realm and refer cases requiring a more profound skill to the professionals.

In conclusion, this investigator feels that para-professionals are very much needed at the New York State University Downstate Medical Center Social Services Department.

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Appendix I

DESCRIPTION OF THE RESEARCH SETTING

The State University Hospital, Downstate Medical Center, a modern, computer equipped teaching and research facility, located at 450 Clarkson Avenue, Brooklyn, New York, opened its doors for service on September 12, 1966.

Included in this facility is a 450 bed Inpatient Department as well as an Outpatient Department. The Inpatients are assigned to different wards or services, in accordance with their treatment needs. The Outpatients are served through the various clinics of the Respective Medical Services.

Patients are usually selected by Physicians on the Medical staff. The criterion for selection has to do with whether or not a given patient's illness constitutes an ample teaching situation. Downstate Medical Center, although State founded, has a very close working relationship with the Kings County Hospital which is City operated. Subsequently, many patients are admitted through Kings County Hospital referral.

Downstate Medical Center is unique among hospitals in that it is the only Medical Center in the United States which has implemented the use of the computer in filing data of all of its medical services. The Downstate Medical Center computer system also serves other non-profit organizations in the Brooklyn area.

PURPOSES

There are five purposes of this study. They are listed as follows:

I. To provide an index of the referral pattern of the various medical services.

II. To categorize referrals in terms of requests for tangible or intangible services.

III. To ascertain whether or not there is a distinct difference between the percent of requests for intangible services during the first six (6) months of operation and the last six (6) months; the expectation here is that as other departments become more aware of the kinds of services provided by the social services department there will be more requests from other departments for intangible services.

IV. To provide an index as to whether or not professionally trained social workers are being utilized most effectively; in other words are they processing referrals that could probably be handled just as effectively by para-professionals.

METHODOLOGY

In conducting this study, the investigator plans to focus initially upon the first six months, (Organizational Stage), and the last six months, (Termination Stage), of the initial seventeen months of operation of the Social Service Department at the State University Hospital, Downstate Medical Center. The first six months and the last six months will be referred to, throughout the study, as the Organizational and Termination Stages or as Stages I and II. (For detailed description see "Definition of Terms")

Handling the study in the above manner will enable the investigator to obtain a good "cross-section" of the referral patterns of the various medical services for the entire seventeen months. On the other hand, he will be able to contrast the first period with the second and gain information regarding: the need for social service by medical services, the utilization of the Social Service Department by the referring professions. This comparative approach will enable the investigator to accomplish the following objectives:

1. To catagorize referrals in terms of requests for tangible and intangible services.
2. To assess the need for case aides.
3. To determine the effect of the educational program of the Social Service Department.

4. To determine whether or not there is a distinct difference between the number and percent of requests for intangible services and tangible services during the two periods.

The investigator plans to consider both periods collectively in relating to the purpose having to do with the following:

1. An index of the referral patterns of the various medical services.

In order to carry out this study, it will be necessary for the investigator to ascertain what referrals were received by the Social Service Department, as well as their sources, during the periods under study. This will be done through the selective sampling method. The investigator plans to examine the referral card file kept in the office of the secretary and collect data regarding: date, name, referral reason, and source, from every other card carrying a date falling within the two periods. This will provide the investigator with a 50% sample which is felt to be reasonably representative. A schedule will be used to collect the data, (see sample schedule included in the appendices.)

The investigator then plans to arrange the collected data in tabular form. Information to be included will pertain to the following:

1. Tangible vs. Intangible referrals, Organizational Stage (I) vs. the Termination State (II).

2. Specific types of tangible and intangible referrals during the two periods.

3. Sources of referrals and their individual referral patterns (Tangible and Intangible).

4. Overall referral patterns covering both periods collectively.

In organizing his approach to the study, it will be necessary for the investigator to draw up an outline. Each chapter will then be developed by providing the reader with a frame of reference to put

him in a position to appreciate and better understand the subsequent data presentation.

The data presentation will be a discussion of findings with reference to specific tables for purposes of clarification.

DEFINITION OF TERMS

In an effort to enhance clarification of the material presented, the terms below are defined as follows:

(1) The Organizational Stage refers to October, November and December of 1966; and January, February and March of 1967.

(2) The Termination Stage refers to October, November and December of 1967; and January, February and March of 1968.

(3) Collaboring Professions refers to associated medical services comprised of doctors, nurses, physical therapists, nurses aides, etc.

(4) Tangible Services are those activities provided by a social service department having to do with helping patients materially or through environmental manipulation. Examples: Referral to welfare department for financial assistance; referral of patient to nursing home.

(5) Intangible Services are those activities provided by a social service department having to do with helping patients and family members resolve emotional problems through the principle use of interviewing, group interaction techniques, psychological support, ventilation of feelings, etc. Examples: Marital counseling, family counseling, supportive therapy.

(6) Para-professional is an individual without two years training in a graduate school of social work.

Schedule

ORGANIZATIONAL STAGE (I)
(1966) Oct., Nov., Dec.
(1967) Jan., Feb., March

TERMINATION STAGE (2)
(1967) Oct., Nov., Dec.
(1968) Jan., Feb., March

(All Cases Fallind Under The Organizational Stage (I) and the Termination Stage (2) Respectively are Checked 1 or 2 in the Stage Column)

Name	Date	Stage	Source	Reason

Appendix II

TABLE 1-A

TANGIBLE REFERRALS DURING THE ORGANIZATIONAL STAGE

Referral Sources

Reasons for Referrals	General Medicine	Diabetics	Arthritics	Surgery	Pediatrics	Clinical Research	Pre-Natal	Hematology	Renal	Cardiology	Rehab-Medicine	Family Planning
Financial Assistance	9	4	2	4	2	1	1	3	5	10		
Home Appliances	2		1	1					1	1		
Employment Finding	2			1			1		1	1		
Employment Correspondence		1								1		
Vocational Rehabilitation												
School Placement									1	1		
Homemaking Services		1			1					4	1	
Visiting Nurse Services	1			1								
Child Care												
Adoption Services							1					
Convalescence Care										1		
Medicare and Medicaid	2	1										
Housing Problems	2	1		1			2		1		1	
Transportation	1			1		1				1		
Locate Patient						1				1		
Informational												
Sub-Totals	19	8	3	9	3	3	5	3	9	21	2	

TABLE 1-B

TANGIBLE REFERRALS DURING THE ORGANIZATIONAL STAGE

Referral Sources

Reasons for Referrals	Outside Source	Neurology	Trauma	Dermatology	Pulmonery	Gynecology	Radiology	Res-Follow up	Urology	Opthalmology	Psychiatry	Orthopedics	Obstetrics	Totals
Financial Assistance		8	1		1	1			1			1		54
Home Appliances														6
Employment Finding		1			2									9
Employment Correspondence														2
Vocational Rehabilitation														
School Placement														2
Homemaking Services														7
Visiting Nurse Services		1												3
Child Care														
Adoption Services														1
Convalescence Care														1
Medicare and Medicaid					1	1								5
Housing Problems														8
Transportation														4
Locate Patient		1												3
Informational														
Sub-Totals		11	1		4	2			1			1		105

TABLE 2

Number and percentage breakdown
of specific Tangible Referrals
During the Organizational Stage

Organizational Stage (I) Referrals (Tangible)	Number	Percentage
Financial Assistance	54	51
Employment Finding	9	9
Housing Problems	8	8
Homemaking Services	7	7
Home Appliances	6	6
Medicaid & Medicare	5	5
Transportation	4	4
Sub-Total	93	
Miscellaneous		
Visiting Nurse Services	3	
Locate Patient	3	
Employment Correspondence	2	Total for Misc. Group 10
School Placement	2	
Adoption Services	1	
Convalescent Care	1	
Sub-Total	12	
Grand Total	105	100

TABLE 3-A

TANGIBLE REFERRALS, TERMINATION STAGE (2)

Referral Sources

Reasons for Referrals	General Medicine	Diabetics	Arthritics	Surgery	Pediatrics	Clinical Research	Pre-Natal	Hematology	Renal	Cardiology	Rehab-Medicine	Family Planning
Financial Assistance	4	2		4		3	3	1		8		2
Home Appliances	1							1				1
Employment Finding	4			1		1			2	1		
Employment Correspondence												
Vocational Rehabilitation								1				
School Placement							1					
Homemaking Services	4			1				1		2		
Visiting Nurse Services												
Child Care	1			1								2
Adoption Services							1					
Convalescence Care	2	1		1								
Medicare and Medicaid	2							1			1	1
Housing Problems	3						1		1		1	
Transportation	3		1	1			1		1		2	
Locate Patient												1
Informational												
Sub-Totals	24	3	1	9		4	7	5	4	11	4	7

TABLE 3-B

TANGIBLE REFERRALS, TERMINATION STAGE (2)

Referral Sources

Reasons for Referrals	Outside Source	Neurology	Trauma	Dermatology	Pulmonery	Gynecology	Radiology	Res- Follow up	Urology	Opthalmology	Psychiatry	Orthopedics	Obstetrics	Totals
Financial Assistance		3	1		1			1		1		2	3	39
Home Appliances														3
Employment Finding								1						10
Employment Correspondence		1												1
Vocational Rehabilitation														1
School Placement		1												2
Homemaking Services					1								1	10
Visiting Nurse Services								1						1
Child Care													1	5
Adoption Services													1	2
Convalescence Care														4
Medicare and Medicaid					1			1					1	8
Housing Problems		1		2										9
Transportation							1							10
Locate Patient		1												2
Informational														
Sub-Totals		7	1	2	3		1	4		1		2	7	107

TABLE 4

Number and Percentage Breakdown
of Specific Tangible Referrals
from
The Termination Stage (2)

Termination Stage (2) Referrals (Tangible)	Number	Percentage
Financial Assistance	39	37
Employment Finding	10	9
Homemaking Services	10	9
Transportation	10	9
Housing Problems	9	8
Medicaid & Medicare	8	7
Child Care	5	5
Sub-Total	91	84
Miscellaneous		
Convalescent Care	4	
Home Appliances	3	
School Placement	2	
Adoption Services	2	Total for Misc. Group 16%
Locate Patient	2	
Visiting Nurse Services	1	
Vocational Rehabilitation	1	
Employment Correspondence	1	
Sub-Total	16	16
Grand Total	107	100

TABLE 5-A

INTANGIBLE REFERRALS, ORGANIZATIONAL STAGE (I)

Referral Sources

Reasons for Referrals	General Medicine	Diabetics	Arthritics	Surgery	Pediatrics	Clinical Research	Pre-Natal	Hematology	Renal	Cardiology	Rehab-Medicine	Family Planning
Counsel and Support	10		1	4		2	5	1		3	1	1
Social Evaluations	2				2	3	20			1		
Psychiatric Screening	7		1				1	1				4
Post Hospital Planning												
Sub-Totals	19		2	4	2	5	26	2		4	1	5
Part 1 Totals	19	8	3	9	3	3	5	3	9	21	2	
Grand Totals Parts 1 & 2	38	8	5	13	5	8	31	5	9	25	3	5

TABLE 5-B

INTANGIBLE REFERRALS, ORGANIZATIONAL STAGE (I)

Referral Sources

Reasons for Referrals	Outside Source	Neurology	Trauma	Dermatology	Pulmonery	Gynecology	Radiology	Res-Follow up	Urology	Opthalmology	Psychiatry	Orthopedics	Obstetrics	Totals
Counsel and Support		1			2						2		1	34
Social Evaluations		2											7	37
Psychiatric Screening	11	7											1	33
Post Hospital Planning														
Sub-Totals	11	10			2						2		9	104
Part 1 Totals		11	1		4	2			1			1		105
Grand Totals Parts 1 & 2	11	21	1		6	2			1		2	1	9	209

TABLE 6

Number and Percentage Breakdown
of Specific Intangible Referrals
from
The Organizational Stage (I)

Organizational Stage (I) Referrals (Intangible)	Number	Percentage
Social Evaluations	37	36
Psychiatric Screening	33	32
Counsel and Support	34	32
Total	104	100

TABLE 7-A

INTANGIBLE REFERRALS, TERMINATION STAGE (2)

Referral Sources

Reasons for Referrals	General Medicine	Diabetics	Arthritics	Surgery	Pediatrics	Clinical Research	Pre-Natal	Hematology	Renal	Cardiology	Rehab-Medicine	Family Planning
Counsel and Support	8	1	1	1	2	2	4	1		1	1	18
Social Evaluations	6		1		6	5	32	1	1			3
Psychiatric Screening	1					1					1	
Post Hospital Planning												
Sub-Totals	15	1	2	1	8	8	36	2	1	1	2	21
Part 1 Totals	24	3	1	9		4	7	5	4	11	4	7
Grand Totals Parts 1 & 2	39	4	3	10	8	12	43	7	5	12	6	28

TABLE 7-B

INTANGIBLE REFERRALS, TERMINATION STAGE (2)

Referral Sources

Reasons for Referrals	Outside Source	Neurology	Trauma	Dermatology	Pulmonery	Gynecology	Radiology	Res-Follow up	Urology	Opthalmology	Psychiatry	Orthopedics	Obstetrics	Totals
Counsel and Support		2				2								45
Social Evaluations		3				2								62
Psychiatric Screening	3	1												7
Post Hospital Planning														
Sub-Totals	3	6				4							3	114
Part 1 Totals		7	1	2	3		1	4		1		2	7	107
Grand Totals Parts 1 & 2	3	13	1	2	3	4	1	4		1		2	10	221

TABLE 8

Number and Percentage Breakdown
of Specific Intangible Referrals
from
The Termination Stage 2

Termination Stage (2) Referrals (Intangible)	Number	Percentage
Social Evaluation	62	54
Counsel and Support	45	39
Psychiatric Screening	7	7
Total	114	100

TABLE 9

Number and Percentage Breakdown

of Tangible and Intangible Referrals

During

The Organizational Stage (I)

and

The Termination Stage (2)

Organizational Stage (I)	No.	%	Termination Stage (2)	No.	%
Tangible Referrals	105	50.4	Tangible Referrals	107	48.4
Intangible Referrals	104	49.6	Intangible Referrals	114	51.6
Total	209	100	Total	221	100

TABLE 10

TANGIBLE REFERRALS, ORGANIZATIONAL STAGE (I)

Number and Percentage Breakdown
from the sources listed.

Sources	Number	Percent
Cardiology	21	19
General Medicine	19	18
Neurology	11	10
Surgery	9	9
Renal	9	9
Diabetics	8	8
Prenatal	5	5
Sub-Total	82	78
Miscellaneous		
Pulmonery	4	
Arthritics	3	
Pediatrics	3	
Clinical Research	3	Total for Misc. Group 22
Hematology	3	
Rehabilitation Medicine	2	
Gynecology	2	
Trauma	1	
Urology	1	
Orthopedics	1	
Sub-Total	23	
Grand Total	105	100

TABLE 11

TANGIBLE REFERRALS, TERMINATION STAGE (2)

Number and Percentage Breakdown
from the sources listed.

Sources	Number	Percent
General Medicine	24	21
Cardiology	11	10
Surgery	9	8
Obstetrics	7	7
Neurology	7	7
Family Planning	7	7
Prenatal	7	7
Hematology	5	5
Clinical Research	4	4
Renal	4	4
Resident Follow-up	4	4
Rehabilitation Medicine	4	4
Sub-Total	93	88
Miscellaneous		
Diabetics	3	
Pulmonery	3	
Orthopedics	2	Total for Misc. Group 12
Dermatology	2	
Opthalmology	1	
Radiology	1	
Trauma	1	
Arthritics	1	
Sub-Total	14	

TABLE 12

INTANGIBLE REFERRALS, ORGANIZATIONAL STAGE (I)

Number and Percentage Breakdown
from the sources listed.

Sources	Number	Percent
Prenatal	26	25
General Medicine	19	18
Outside Sources	11	11
Neurology	10	10
Obstetrics	9	9
Clinical Research	5	5
Family Planning	5	5
Sub-Total	85	83
Miscellaneous		
Surgery	4	
Cardiology	4	
Arthritics	2	
Pediatrics	2	Total for Misc. Group 17
Hematology	2	
Pulmonery	2	
Psychiatry	2	
Rehabilitation Medicine	1	
Sub-Total	19	
Grand Total	104	100

TABLE 13

INTANGIBLE REFERRALS, TERMINATION STAGE (2)

Number and Percentage Breakdown
from the sources listed.

Sources	Number	Percent
Prenatal	36	31
Family Planning	21	18
General Medicine	15	13
Pediatrics	8	7
Clinical Research	8	7
Neurology	6	6
Sub-Total	94	82
Miscellaneous		
Gynecology	4	
Obstetrics	3	
Outside Sources	3	
Hematology	2	
Arthritics	2	Total for Miscellaneous Group 18
Rehabilitation Medicine	2	
Renal	1	
Cardiology	1	
Surgery	1	
Diabetics	1	
Sub-Total	20	
Grand Total	114	100

TABLE 14

Number and Percentage Breakdown of Referrals
from the Various Sources,
The Organizational Stage (I)
and
The Termination Stage (2)
Combined

Sources of Referrals	Number	Percent
General Medicine	77	18
Pre-Natal	74	17
Cardiology	37	9
Neurology	34	8
Family Planning	33	8
Surgery	23	5
Clinical Research	20	5
Obstetrics	19	4
Outside Source	14	3
Renal	14	3
Pediatrics	13	3
Diabetics	12	3
Hematology	12	3
Rehabilitation Medicine	9	2
Pulmonery	9	2
Arthritics	8	2
Miscellaneous		95
Trauma	2	
Dermatology	2	
Gynecology	6	

Table 14 (cont'd)

Radiology	1	
Resident Follow-up	4	
Urology	1	Total Miscellaneous 5
Opthalmology	1	
Psychiatry	1	
Orthopedics	3	
Grand Total	430	100